REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used ***after*** *an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Bracknell Forest Borough Council** **2. Chartered Institution of Highways and Transportation** **3.**
1	**CORONER** I am Peter J. Bedford, Senior Coroner, for the coroner area of Berkshire.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 9th October 2012 I commenced an investigation into the death of Michael Arthur Warren. The investigation concluded at the end of the inquest on 10th July 2014. The conclusion of the inquest was a narrative as attached.
4	**CIRCUMSTANCES OF THE DEATH** Michael Arthur Warren died from serious head injuries suffered when the car he was driving was struck on its roof by the large branch of a mature oak tree that unexpectedly fell without warning as he drove beneath it on 5th October 2012.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) The evidence at the Inquest revealed that Bracknell Forest Borough Council employ Highways Inspectors to carry out driven and walked inspections in order to attempt to identify any potential hazards that might impact adversely on road users. (2) The Highway Inspectors were expected to identify a range of potential problems including potholes in the road, damaged or obscured signage and potential hazards from trees abutting the highway which were often of considerable height. There was little by way of guidance given to Highways Inspectors who had developed their own system of drive-by investigations conducted at a speed rarely less than thirty miles per hour. (3) The evidence highlighted the limited nature of training provided to Highway Inspectors in identifying potential hazards from trees. The two Inspectors who conducted a drive-by survey two days before the branch fell and killed Mr Warren and who had noted nothing of concern, had not completed any form of tree training since a two day course some seven years earlier. Another Highway Inspector who gave evidence at the Inquest, had never attended a formal training course with regard to tree hazards. (4) There is therefore a need for appropriate guidelines to be provided by Bracknell

	Forest Council to Highway Inspectors to ensure that they are properly trained in tree issues; that they have an appropriate system of work that ensures that they drive at a speed appropriate to maximise the chances of identifying tree hazards and that there should be a series of inspections which are limited to only the inspection of trees. (5) The evidence also revealed that there was very little by way of clear, detailed guidance available to Local Authorities as regards the appropriate systems of highway inspection of trees abutting the highway. There is a potential need for clear direction from a suitably qualified source to assist Local Authorities in this crucial role. (6) The owner of the land on which the relevant oak tree stood lived abroad and had no arrangements for professional review of the trees on his property, in particular those that were close to the highway and therefore a potential hazard to road users. It was of concern that the lack of active management of the owner's land continued some two and a half years after Mr Warren's death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday 12th September 2014. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons - Bracknell Forest Borough Council, The Chartered Institution of Highways and Transportation and Mr [redacted] I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**17th July 2014** **Senior Coroner for Berkshire**